In this work, we shall examine mental health service users' experiences of multiple discrimination in greater detail.

In response to Suning Chen and colleagues, we did examine the number of years of education in our study, the mean for our sample being 12·6 years (SD 3·3). Our interviews were largely done in urban centres, and each site was asked to recruit for interview people with a clinical diagnosis of schizophrenia who were reasonably representative of all such people in the local area. We did not collect further information on severity of illness.

Our reported regression model supports the comment that those who have been diagnosed a long time ago should report a larger number of discrimination experiences that those who have been recently diagnosed. In fact we did find that time since diagnosis was associated with increasing negative experienced discrimination, such that, as time since diagnosis moves from "less than 5 years" to "greater than 15 years", negative discrimination increased by 1·9 units on average.

The comments by M V Karidi and colleagues and by Catherine van Zelst are a welcome way of sharing experiences and continuing the discussion on possible interventions to reduce stigma and discrimination.[3]

We declare that we have no conflicts of interest.

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2 Phelan JC, Yang LH, Cruz-Rojas R. Effects of attributing serious mental illnesses to genetic causes on orientations to treatment. *Psychiatr Serv* 2006; **57:** 382–87.
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## Health care for detainees

Your Editorial, "Health care for prisoners and young offenders" (Feb 21, p 603)[1] describes recent Healthcare Commission (HCC) reports about the deplorable care of prisoners and young offenders in the UK. The situation of 25 000 people (including 2000 children[2]) subjected to administrative immigration detention annually is, if anything, worse.

We and colleagues in the Medical Justice Network have examined and documented the medical conditions of more than 500 such detainees in the past 3 years. We have found:

(a) Failure to examine, diagnose or refer serious disorders including tuberculosis, AIDS, epilepsy, sickle-cell crises, post-traumatic stress disorder, and psychoses.

(b) Transfer to detention centres without medical notes or essential medication.

(c) Unlawful failure to document blatant evidence of torture (which should usually prohibit detention[3,4]) and of assault by staff contracted to the Home Office.[5]

More than 75% of the people we have seen have been released shortly thereafter, suggesting that their original detention was inappropriate. In many cases compensation has been paid to them, at tax-payers' expense.

Detention centre health care (unlike that in ordinary prisons) remains the responsibility of the Home Office, which has no known clinical competence. Most of the 10 UK immigration detention centres registered with the HCC in 2008, some 2 years later than promised by the then Immigration Minister.

There is an urgent need for:

(a) Transfer of responsibility for detainees' health care to the Department of Health.

(b) Investigation of detention centres by the HCC or its successor.

(c) An end to the detention of children.

Signatories of this letter are: Frank Arnold, Miria Beeks, Jonathan Fluxman, Indrajit Ghosh, Charmian Goldwyn, Cornelius Katona, Nick Lessoff, Joseph O'Neill, Ben Robinson, Emily Spry, and Felicity de Zulueta. All of the signatories receive referrals through the Medical Justice Network; some of us are sometimes paid for medicolegal reports as a result.

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1 The Lancet. Health care for prisoners and young offenders. *Lancet* 2009; **373:** 603.
2 The Lancet. Health care for children in UK detention centres. *Lancet* 2008; **372:** 1783.
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4 UK Borders Agency. Rule 35: reports of special illnesses and conditions (including claims of torture) received from immigration removal centres, regarding detainees. http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/rule35reports.pdf?view=Binary (accessed Feb 23, 2009).
5 Wistrich H, Ginn E, Arnold F. Outsourcing abuse: the use and misuse of state-sanctioned force during the detention and removal of asylum seekers. http://www.medicaljustice.org.uk/images/stories/reports/outsourcing%20abuse.pdf (accessed Feb 23, 2009).

The England and Wales prison health service[1] is leading Europe in its integration between prison and public-health services. It is one of the very few in the world where questions such as quality assurance and clinical governance can seriously be considered, since the service is approaching equivalence to what is available in the community. In our experience, many patients of prison health services would offer approval ratings higher than they experience in the community. In some countries, prison health remains isolated from other health services, the recruitment of doctors and other health-care staff is a matter of appointing whoever is available, and the service provided is far from meeting even basic international standards and human rights.

As a publication with global impact, your Editorial was a little

too local in perspective and missed the opportunity to call for wider recognition of the importance of good prison health for public heath. 100 years ago, Winston Churchill said that "the mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country".

Despite the deficiencies to which you rightly draw attention, it would not take much for the UK's prison health services to lead the rest of the world towards the civilised service Churchill no doubt had in mind.

We declare that we have no conflicts of interest.

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1 The Lancet. Health care for prisoners and young offenders. *Lancet* 2009; **373:** 603.

## Negative and positive effects of trade on health

Chantal Blouin and colleagues (Feb 7, p 502)[1] provide a theoretical framework linking trade liberalisation and health outcomes. A basic feature of their model is that it only takes account of the negative effects on health. We submit that Blouin and colleagues should explicitly allow for potentially favourable effects.

From a systemic perspective, it is plausible and useful that such conceptual models allow for positive and negative effects, whether regulatory or compensatory, intended or unintended. From an observational perspective, a series of negative effects of trade liberalisation on health have been described,[2,3] although the interpretation still needs further clarification.[4] But some evidence also points to favourable effects.[5]

Life expectancy rapidly increased after trade liberalisation in some former communist countries in eastern Europe[3] (although such countries also benefited from high levels of social capital and infrastructures at this time). In Poland, the improvement was attributed to the striking decrease in cardiovascular mortality, which is probably related to the shift from saturated fats (eg, butter, lard) to unsaturated fats (vegetable oils) and increased availability of fruits and vegetables.[5]

The food industry has become more willing to reduce the salt content of selected foodstuffs under pressure from various health organisations. Better health at population level could also result from improved food security as a result of the higher standards demanded by globalised production and distribution.

The global effects of trade liberalisation on health are still largely unknown. In this context, it is probably sensible to develop and use conceptual models that take account of both positive and negative effects.

We declare that we have no conflicts of interest.

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## Alcohol misuse: local innovations are also important

Your Editorial on alcohol misuse (Feb 7, p 433)[1] highlights the need for a global response aimed mainly at preventing overconsumption. Our experience in West Lothian, UK, has shown that local initiatives are also essential in the prevention and management of alcohol misuse. The project described below is part of a whole-population approach based on research by WHO.[2]

Operation Floorwalk involves schools, police, voluntary organisations, local authority, and the National Health Service. A team of individuals from these organisations identifies local "hot spots" of youth drinking that are then targeted during afternoons and early evenings. Young people younger than 16 years who are under the influence of alcohol are taken to a police station for their safety. The young people and their parents or carers are then counselled and offered further support through the voluntary sector, either in the form of specialist alcohol advice, social skills training, or group work.

To date, almost 300 young people have been through this innovative programme. Information gathered from the young people has helped reveal the high levels of need in this population, ways that young people obtain alcohol, and young people's views on alcohol. Short-term data on outcomes in 100 of these young people show that 74 participants reported reduced alcohol intake. For some individuals, the support offered through the programme had a major positive effect—for example, one participant was helped to return to education after a long absence from school.

Operation Floorwalk has therefore highlighted the importance of local initiatives and support for individuals.

We declare that we have no conflicts of interest.

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1 The Lancet. Alcohol misuse needs a global response. *Lancet* 2009; **373:** 433.